Table 3: Ten best practices

Best Practice	Description
1. Develop a comprehensive treatment plan.	• The "plan" consists of the nine strategies that follow. • The plan articulates to your patient that you – have a well-thought-out plan of care that extends far beyond the sale of a device and – place the patient at the center of that plan.
2. Use a patient-focused "income" measure.	• You have a number of well-validated and well-researched needs-assessment instruments: – Hearing Handicap Inventory for the Elderly (HHIE) – Abbreviated Profile of Hearing Aid Benefit (APHAB) – Glasgow Hearing Aid Benefit Profile (GHABP) – Consumer-Oriented Scale of Improvement (COSI) Use them — they help you and your patient determine where to go and how to get there.
3. Use *meaningful* clinical tests.	• The majority of patients who seek our help complain of problems understanding conversations in noisy environments. • Use a speech-in-noise test (e.g., QuickSIN, HINT). • Live voice presentation of an abbreviated monosyllabic word list at a single presentation level is of little value.
4. Establish patient-specific treatment goals.	• What does the patient want to achieve at the conclusion of treatment? – What do they want to be able to do that they can't do now? • Treatment goals need to be SMART: – **S**pecific – **M**easurable – **A**chievable – **R**ealistic – **T**ime-limited
5. Select hearing aid features on the basis of the treatment goals, not the audiogram.	• The audiogram is an impoverished indicator of the status of the auditory system. • Two patients with the same audiogram can have dramatically different auditory processing abilities, communication needs, and, consequently, treatment goals requiring different features.
6. Verify the hearing aid performance parameters with test box and probe microphone measures.	• The aided hearing aid response reflects the interaction between (a) the electroacoustic and physical properties of the hearing aid and (b) the acoustic and physical properties of the external and middle ear • The "Best Fit" feature risks overamplifying and/or underamplifying. • *Trust, but … verify!*

7. Validate your treatment plan.	The success of your intervention will be determined by the extent to which you have met the patient's expectations and goals as *determined by the patient.* For example: • Can the patient hear the TV at a volume that's comfortable for his wife? • Can the patient understand the bids being called out at the weekly bridge game he plays with his neighbors? • Can the patient understand his wife in the restaurant that they frequent after church every Sunday?
8. Evaluate for and prescribe hearing assistive technology (HAT), as appropriate.	Despite your and your patient's best efforts, one or more of the goals might not have been satisfactorily achieved with hearing aids. HATs might be the solution.
9. Itemize your fees.	Bundling is a practice that • Obscures your professional value and • implies a product purchase, not payment for professional services. If you commoditize your services then your patient will shop around for the lowest cost.
10. Provide postfitting AR services.	• Many of our patients will continue to experience problems despite being provided with the latest hearing aid technology fit by expert clinicians. • Research has demonstrated that post–hearing aid intervention in the form of auditory training and/or group AR can improve outcomes.